BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

DETERMINING FACTORS IN COMMUNITY REFERRALS BY MEDICAL SOCIAL WORKERS AT CUSHING VETERANS ADMINISTRATION HOSPITAL

A Thesis

Submitted by

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CHAPTER I

INTRODUCTION

The concept that veterans of our wars are deserving of federal and local benefits is generally accepted and has a firm logical basis. These people interrupted their family lives, their education, and their careers because of national emergencies, and many of them suffered physical or mental impairment through their service to the country. Also, now that these veterans have returned to their communities, it is to be remembered that whatever is done for them is indirectly for the good of the community, as well; presumably the younger veterans will be contributing members of the community, and therefore whatever will help them to function at their optimal level will eventually be of profit to the community. In the case of older veterans, these people are the molders of our future citizens and therefore their best adjustment is also essential to the functioning of the community. Social workers can fill a useful integrative role in helping these veterans to use advantageously the facilities available to them, whether these be particularly for veterans or for the citizenry as a whole. In the practice of medical social work in a Veterans Administration hospital, there frequently are opportunities for the social worker to aid veterans in contacting local agencies which can be of

help to them. Referrals to these agencies are made in the spirit of preserving the veteran's initiative and independence of action and encouraging him to think of himself as a part of the community as a whole, in addition to being a part of the veteran group.

The former chief of social service in the Veterans Administration has said of the program:

> The fundamental purpose is to enable disabled veterans to use to maximum advantage for becoming fully rehabilitated, the array of Veterans Administration benefits to which they have right, as well as the services available to them in their communities through other agencies... The success with which this vast category of citizens --- veterans --- will become reintegrated into their homes and able to carry a satisfying, useful role in their communities, depends to a major extent upon the degree of co-ordination and inter-lacing of services among tax-supported agencies --- federal, state, and local. Such co-ordination requires detailed mutual understanding of agencies' legal functions, of their broadest possible boundaries, and of their absolute limitations.[1]

In the practice of social service, where the attempt is made to see the individual as a whole person and where his many needs are taken into consideration, the matter of division of labor, and hence referrals to other resources, assumes great importance. This is particularly true in medical social service with acute cases, as the social worker often can see the patient only during his brief period

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[1]J. H. Stipe, "The VA Social Service Program," Public Welfare, Vol. 5, No. 3, March, 1947, p. 2.

of hospitalization. In the interests of specialization and efficient operation, any one agency presumably must have limits as to the service which it offers. Therefore the one unit, having helped the client to the extent possible within its function, and having gotten a picture of the needs and potentialities of the client, may refer him elsewhere for certain specialized services, if it is believed that these will be helpful in his adjustment. Many factors enter into the eventual effectiveness of such a referral, and because of the presumed importance of the referrals to the happiness of the client, these factors bear observation and receptivity to change. The present study is directed toward examining some of these factors -- those involving client attitudes, social service action, inter-agency relationships, and technical referral devices.

In considering client attitudes, it will be seen that not only the factors usually influencing the acceptance of referrals are present, but also some specific grouping of attitudes because of the common factor shared by the present study group, in that they are "veterans", with the many connotations and implications that that involves. Thomas refers to one aspect that may result from being a war veteran and explains how this affects the attitude toward social service referrals:

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Referral from one agency to another has more

> than the usual meaning to the veteran. He is apt to feel that he is being given the "run around." He has faced so much red tape and reported to so many people before being given his discharge. Each has informed him of rights and privileges. The chances are that in many instances no one has actually done much for him except to tell him where to go. The veteran wants "action." This need must be met and at the same time a "delaying process" must go on to help him slow down and take things in his stride.[2]

Ginsburg recognizes and handles another such attitude possible among veterans which might not be for their best eventual interests:

> The veteran knows that the agency is there to serve him because he is a veteran and has earned that right, but the danger of becoming a pressure agency that will get things for veterans simply because they are veterans and without regard to their total adjustment is one that the staff consciously avoids.[3]

In considering social service action, it is obvious that a large part of the decision regarding referral is the responsibility of the social worker, as in locating a helpful community resource, preparing the patient and his family for this referral, etc. Thornton and Knauth found, in their study in trying to promote the health and happiness of their patients upon discharge by referral to community agencies that could aid the patient further, that:

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[2]D. V. Thomas, "The Veteran as Seen in a Private Family Agency," The Family 26: p. 207, October, 1945.

[3]E. L. Ginsburg, "The Case Work in a Veterans' Service Center," National Conference of Social Work, 1945, p. 131.

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> Success in supplying needed resources was determined in large part by the ability and willingness of the patient and his associates to co-operate in making and carrying out a plan of relief; in part by the availability of resources in the community; and in part by the ability of the hospital's social workers to discover and utilize available resources, whether within the patient's own immediate sphere of influence or provided by agencies in the community, i.e., health and welfare agencies of city, state, or nation. Having information both of unfavorable social factors thought to affect the patient's health and care and of resources available to relieve or to rectify these factors, the doctor was in a position to advise concerning the selection of the best obtainable environment ... The patients were informed of what aid was available and how it was to be secured, and were consulted whenever choice was possible as to their preference for source of aid.[4]

In considering inter-agency relationships, as has been suggested, this seems to merit attention in helping the veteran to think of himself in terms of the larger community as well as his veteran group. Also, the fact that the Veterans Administration and its many parts comprise in some ways and may be looked upon by outsiders as a self-sufficient operating system may necessitate a more conscious effort on the part of the Veterans Administration social service staff to unite its function with that of other social service agencies in the community. It must be remembered, too, that the inter-agency relationship involves sharing, rather than a one-direction contribution; therefore, the Veterans Ad-

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[4]J. Thornton and M. Knauth, The Social Component in Medical Care, p. 225 - 226.

ministration social worker must be prepared to give services as well as ask for them, in the manner that Thomas suggests:

> The ... problem relates to better co-ordination of services, not only within a community but also between the military, veterans, and civilian agencies. Veterans Administration and the Family Welfare Association of America have laid the groundwork for referrals from veterans hospitals to private family agencies. Little has been done thus far at the local community level to facilitate such referrals or to develop co-operative working relationships. More effective means are needed for getting information, with the consent of the veteran, from military and veterans hospitals. Information pertinent to the problem that brings the veteran to the agency is essential for effective treatment. Often times this is something the veteran himself cannot give.[5]

Methods of the social worker in referral may vary according to the nature of the casework relationship within the hospital, i.e., whether this relationship was of the intensive or short-term variety. Where there has been intensive casework within the hospital and where the community agency will be continuing this work, "... the technique ought to be one of a relay team with both members in full correlated motion, making the transfer an almost imperceptible process."[6] In the characteristically and often necessarily brief handling of the other cases by the medical social worker, "... it may become a challenge to hospital

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[5]Thomas, op. cit., pp. 205-6.

[6]K. Freudenthal, "Participation of the Community Agency in Hospital Discharge Planning," Journal of Social Casework 30: p. 421, December, 1949.

social service to increase the significance of its contribution to discharge planning by developing techniques of short, concentrated contacts designed to utilize the capacity for movement of all involved."[7]

The technical referral devices also warrant thought, as regards effectiveness, mutual understanding, and the ever-present problem of time-conservation, which the medical social worker faces. Some similarity may exist between the hospital set-up, with its rapid turn-over of veteran cases, and the work of a veterans service center. It may therefore be of interest to note some of the procedures Ginsburg mentions for the handling of referrals in such a center:

> All referrals are preceded by telephone discussion with the agency to which the veteran is going, and specific appointments are made, whenever possible.. To determine the efficacy of our referrals, a follow-up form is sent with each referral and is followed by another at the end of one month.[8]

In applying this general discussion of referrals to the social service referrals made in Veterans Administration hospitals, the following comments from one of the technical bulletins will be of interest:

> A referral consists in helping the claimant to use a community resource outside the Veterans Administration. The recognition, by other Veterans Administration personnel, of the need for referral may arise in the process of reviewing eligibility, or

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[7] Ibid., p. 423.

[8] Ginsburg, op. cit., p. 130.

> during medical examination or treatment; or by social workers in the course of their social case work or while making social evaluation for other Divisions. The purpose of a referral is to help that person meet his needs when he is ineligible for a Veterans Administration service, or requests a service not provided by the Veterans Administration. This may involve consideration with him as to the nature of the problem for which he is seeking help and agreement to a plan for meeting his needs through the use of community resources. It may include clearing with the agency to which a referral is planned, discussion of the situation, and verification of agency's acceptance. The responsibility for referral of claimants (except minor wards) to community social agencies for assistance with their social problems rests with Social Service. However, in many localities, and in relation to certain types of problems, the suggestion to the claimant by the Veterans Administration department to which he has brought his problem, that he get in touch with a certain community social agency, will fully meet the claimant's need. Advance Social Service planning with the other Veterans Administration Divisions and with community agencies as to general policies in this connection is necessary, however, to avoid duplication of action within and outside the Veterans Administration and ensure appropriate and effectual referrals.[9]

A study of the referrals thus made may be useful not only in examining them as a general social work tool but also in considering the working relationship between a Veterans Administration facility and local resources, as directed toward aiding the individual veteran.

> It is realized that all efforts to develop the Veterans Administration social service program into one program, conducted by one staff, will have no vitality and reality unless this service builds secure working relationships with the profession outside the Veterans Administration.[10]

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[9]Veterans Administration Technical Bulletin TB 10A-198; "Referrals to Other Agencies," August 29, 1949.

[10]J. H. Stipe, "Social Service in the Veterans Administration," Survey 84: 48-9, February, 1948.

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[10] R. S. Stipe, "Social Service in the Veterans Administration," Survey 84: 45-6, February, 1948.

SCOPE OF THE STUDY

The present study encompasses the complete group of eighty-six medical social service intake cases, new or re-opened, at Cushing Veterans Administration Hospital during the month of March, 1950. The social service records of these patients were read and notations were made about each, according to a systematized schedule of points pertaining to referral to other agencies outside the hospital. Because of the number of cases involved, no other sources of data were consulted. This material was then tabulated for the purpose of comparisons and conclusions.

The month of March, 1950, was chosen as representing a fairly recent and wieldy group of cases, most of which would be closed by the time of the study. It was felt that this month would not be an unusual month in terms of the influx of cases, e.g., as in an autumn month, when many older, non-service-connected patients might seek hospital admission for shelter during the winter. Some of the cases had been opened and closed by social service previously (as where the patient had former admissions to the hospital). Some of the cases were re-opened following the period of time under present study. However, for purposes of simplicity and uniformity, the present group includes only the intake load of March, 1950, and carries this group only until the first

closure of the cases following this date, whatever month that happened to be. It is hoped that this study will yield significant data on questions such as the kinds of services available to veterans in their communities, the attitudes of the veterans regarding possible referrals, the co-operation shown by the family of the patient, individual factors in the patient's self or situation which affected referral, the types of help which the social worker thought the veteran needed from the community, etc. Also, it may be that some of the more specific details will prove helpful to the Cushing Veterans Administration Hospital social service staff in future considerations of methods; such points might include the length of hospitalization per patient prior to the opening of the social service case, the length of time the social service case continued, the number of contacts made, etc.

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CHAPTER II

THE SETTING OF THE STUDY

> The Veterans Administration as it is operating today is the result of a consolidation, on July 21, 1930, of three federal agencies serving veterans: United States Veterans Bureau, Bureau of Pensions, and the National Home for Disabled Volunteer Soldiers. The Veterans Administration is an independent establishment of the executive branch of the federal government authorized by Act of Congress and created by Executive Order. The Administrator of Veterans Affairs is appointed by, and is responsible to, the President of the United States.[1]

This reorganization in 1930 was for the purpose of providing uniformity and accessibility of services to men and women veterans of United States wars. Of the many federal benefits provided for these veterans, medical care is one of the most important. This is evidenced by the fact that there are now 150 Veterans Administration hospitals throughout the United States and its territories. Patients are admitted to these hospitals on the following priority basis: 1.) veterans needing emergency care; 2.) those suffering from injuries or diseases incurred or aggravated in line of duty during war-time service; and 3.) those who are unable to pay for private treatment of non-service connected injuries or illnesses. Veterans with a disability incurred in peace-time service in the line of duty may also be admitted.

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[1]Jack H. Stipe, "Social Service in the Veterans Administration," Journal of Social Casework, February, 1948, p. 43.

Patients accepted for treatment are those who were discharged or separated from the armed services under conditions other than dishonorable. A high caliber of treatment has been the standard in these Veterans Administration hospitals, and this treatment is provided without cost to the veteran.

The use of social workers has increased and developed in the Veterans Administration, particularly following World War II and its natural sequel of a large veteran group. Though social service was a part of the Veterans Administration from the time of the consolidation in 1930, there were only seventy-four social workers in 1945, before the expansion. There are presently a total of 1400 social workers in the Veterans Administration, 750 of these being regional office personnel and the remainder being hospital personnel. The entire social service division is affiliated with the Department of Medicine and Surgery, a sub-division of the Veterans Administration. The operation of social service departments in individual hospitals is established by the central office in Washington, D. C., and by the policies that the individual hospital social service departments have established in working with their own medical-social teams. The objectives of the medical social worker in this setting involve using the specialized skills of social service to help the veteran to utilize hospital or out-patient treatment to the best advantage, to retain the health gains made

and avoid unnecessary relapses, and to readjust to his home and community, upon discharge. The social worker co-operates with the other members of the medical-social team --- physicians, nurses, and rehabilitation personnel --- in understanding the veteran and his condition. The social worker often consults with the family of the patient and makes other community contacts for the veteran. The social service staffs are selected according to strict United States Civil Service and professional requirements as to training and experience.

Cushing Veterans Administration Hospital originated on October 1, 1946, having been converted from an army hospital. Its present capacity is 1100 beds, which are allocated as follows:

Surgical	220
General Medical	235
Tuberculosis	120
"Closed" Neuropsychiatric	108
"Open" Neuropsychiatric	83
Paraplegia	120
Neurosurgical	47
Aphasia	20
Epilepsy	26
Neurological	79
Women's Ward	42
Total	1100

This hospital is primarily for the diagnosis and treatment of acute conditions. It therefore has a brisk pace of admissions and discharges, and there are waiting lists of patients for some wards. In conformity with the general Veterans Administration policy of maintaining high standards of professional practice and keeping abreast with the various fields, Cushing Veterans Administration Hospital carries on research and training programs. The trainees include physical therapy, occupational therapy, clinical psychology, and social work students. There are residencies available in medicine, surgery, neurosurgery, neurology, and psychiatry, which are approved by the Deans' Committee of the Harvard, Tufts, and Boston University medical schools. Consultants in the medical, surgical, and psychiatric specialties aid in the treatment of the patients and help in teaching the staff members.

The social service department was established with the opening of the hospital in 1946. Utilizing the general policies of the Veterans Administration and the underlying philosophy of social service, the department has continued to work with the professional and managerial representatives of the hospital in formulating a program that will be beneficial to the patients. Medical social ward rounds are conducted on some wards and 100% review on some wards, such as the tuberculosis section. Some experimental work is also

carried on by the department; an example of this is the current study, where patients are being interviewed at the time of hospital admission rather than following a possible later request after they are hospitalized; it will be observed if this early contact proves to be beneficial to the patient in his problems, if it will help to avoid unnecessary hospitalizations, and if it will be helpful to the other team-members in their work with the patient.

The current social service staff of twelve members includes the chief social worker, a psychiatric case supervisor, a medical case supervisor, three psychiatric case workers, five medical case workers, and one worker associated with the Harvard research unit in epilepsy.

CHAPTER III

THE GROUP OF PATIENTS

The project group includes three females and eighty-three males. Eighty-one of the veterans are classified as belonging to the white race, two as belonging to the yellow race, and three as belonging to the negroid race. According to their statements, the group is divided into fifty-five Catholics, twenty-seven Protestants, one Jew, and three without religious affiliations. Seventy-nine of these veterans were born in the United States, while two were born in China, and one each in Italy, Armenia, Poland, Russia, and England. The majority are Massachusetts residents, with only thirteen coming to the hospital from other states. Fifty-three are married, nineteen are single, seven are divorced, six are widowed, and one is legally separated from his wife. Thirty-five said they had dependents other than a wife, and fifty-one said they had not.

In regard to their illness which brought them to the hospital, the diagnoses include twenty-four cases of heart and associated circulatory disease, four cases of cancer, six cases of tuberculosis, six cases with duodenal or peptic ulcer, thirteen cases of psychogenic symptoms without detectable organic lesion, fourteen acute illnesses other than the above-named, eighteen cases entering for treatment of a

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chronic condition, and one illness that was as yet undiagnosed when the patient left the hospital against medical advice.

The group contains four unemployed and nine retired persons, three students, one farmer, two nurses, one detective, one letter-carrier, eighteen heavy laborers, five domestic or kitchen helpers, four clerical and sales people, five managerial and small business men, six routine factory workers, and twenty-seven workers using a special skill, as in cabinetmaking or electrician jobs.

With ten of these veterans, their illness at the time of the study is for a service-connected condition, while the other seventy-six are hospitalized for non-service-connected conditions. Forty receive Veterans Administration pensions, either for a disability suffered during their period of service or for non-service-connected total disability; forty-six do not receive such a pension. Formerly, sixty-seven of these veterans were army personnel, sixteen were Navy members, and two were Marines; the service branch of one veteran was not given. Four are Spanish-American War veterans, thirty-seven are World War I veterans, forty-two are World War II veterans, one is a veteran of both World War I and II, and one served during peace time; the dates of service of one man are unknown, but he is receiving a service-connected pension.

In view of the widely-held opinion that the war service acted as a disrupting influence on the young person's life, it may be of value to cite the figures pertaining to the age at the time of entrance to service and the length of service for these veterans. These will be listed in terms of mean, mode, and median, to give a picture of the distribution; e.g., for the mean age of the group, the sum of all of the veterans' ages, in years, was divided by the number of veterans; for the modal age, that age was taken which occurred most frequently among this group; for the median, all of the ages were arranged in a series according to their numerical value, and the midpoint of the series was taken. In this group, the information necessary for computation was not available on three veterans. Of the remaining eighty-three, the mean age at the time of entrance to service was found to be 24.3 years; the mode was twenty-four, while the median was 24.09. The mean number of months of service for this group of eighty-three was found to be 28.3; while the mode was twenty-two, and the median was also twenty-two months.

Eight of these people were known to the Cushing Veterans Administration Hospital social service staff prior to March of 1950. Seven of the total number of cases were reopened following the period of this project. In addition to these, one patient received social service both before and after the present period of study.

TABLE I

AGE OF VETERAN GROUP IN MARCH 1950*

Age in Years	Number of Veterans
20 - 27	11
28 - 35	22
36 - 43	8
44 - 51	2
52 - 59	27
60 - 67	9
68 - 75	6

*The age of one veteran was unknown.

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CHAPTER IV

THE REFERRED CASES

A descriptive breakdown of the referred cases may now be in order, to illustrate the general pattern of incoming requests and the resultant referrals. Chapter V will deal with the non-referred cases, and Chapter VI will consist of further comments on the analysis of the available statistical data, to precede the summarizing and concluding remarks of Chapter VII.

Included in this category of referrals are those instances where the social worker made a direct contact with a community agency in referring the patient and his family, where the social worker explained the community resource but allowed the patient or his family to initiate their own action with the facility, or where the social worker was active in the plan for the patient though the actual mechanics of referral were handled by the physician. This last method occurred in a few of the referrals of veterans made to domiciles, as this step does not require communication of the social worker with the domicile, unless she has information on the patient which she thinks should be shared. Forty of the total eighty-six cases were classed by the writer as referrals, forty-six as non-referrals.

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Six of the forty referred cases partially illustrate

the range of services which individual patients may require and the variety of resources which are available to them near their place of residence. One foreign-born man, who would soon be returning home but who was faced with an eventually terminal illness, was worried about the future of his large family of young children and his wife, who could not speak English well. Employment, financial, and social problems were anticipated, and the patient eagerly accepted the worker's suggestion that a family caseworking agency might be of assistance. The worker completed a telephone referral to an agency and mailed in a more complete summary. Another man, who was to be discharged but who retained some paralysis, hesitated to return home because he was afraid his care would be too strenuous for his wife; this worry was eased by the social worker's referring him to the Visiting Nurse Association. The third man, still a young person, had been handicapped since boyhood by stammering, and this had affected him in many areas of his life. The worker described a good speech clinic near his home and tried to help him see the advantages of treatment and the naturalness of attending the clinic. He was reluctant to seek treatment. The social worker thought he was a person who should not be pressed too much, and she therefore focused her service on this preparatory work, hoping he would decide in favor of the clinic later. The fourth man needed a suitable apartment, and at

the range of services which individual patients may require and the variety of resources which are available to them near their place of residence. One foreign-born man, who would soon be returning home but who was faced with an eventually terminal illness, was worried about the future of his large family of young children and his wife, who could not speak English well. Employment, financial, and social problems were anticipated, and the patient eagerly accepted the worker's suggestion that a family caseworking agency might be of assistance. The worker completed a telephone referral to an agency and mailed in a more complete summary. Another man, who was to be discharged but who retained some paralysis, hesitated to return home because he was afraid his care would be too strenuous for his wife; this worry was eased by the social worker's referring him to the Visiting Nurse Association. The third man, still a young person, had been handicapped since boyhood by stammering, and this had affected him in many areas of his life. The worker described a good speech clinic near his home and tried to help him see the advantages of treatment and the naturalness of attending the clinic. He was reluctant to seek treatment. The social worker thought he was a person who should not be pressed too much, and she therefore focused her service on this preparatory work, hoping he would decide in favor of the clinic later. The fourth man needed a suitable apartment, and at

his request the social worker sent a letter to a veterans housing project which he wished to enter; as the apartments were not quite completed, he was put on a waiting list by the housing authority. The next patient, an elderly man, was concerned about how his wife was getting along at home alone; this concern was of course not facilitating treatment, at at the caseworker's telephoned request, the Red Cross in the veteran's home town agreed to visit the wife. Affairs at home were found to be satisfactory and the Red Cross agreed to keep in touch with the wife. The last of these six men had a dangerous circulatory disease in addition to some intellectual and emotional deficiencies; he was interested in finding a job which he might fill and in getting occasional financial assistance, when his illness would prevent him from working. He was re-referred, by letter, to his local department of public welfare, which had been able to assist him with these aspects in the past.

In three cases, referral was made to the Veterans Administration Regional Office in the patient's town. One involved asking that the Regional Office offer casework services to the patient, as he was rejecting a mental hygiene clinic referral and the worker thought the Regional Office could help him to accept this. In another case, the Cushing Veterans Administration Hospital physician and caseworker thought the Regional Office could serve the patient and his

family by visiting the home and discussing precautions that should be used there, as the patient had had tuberculosis and the family lived in crowded quarters. In the third case, the veteran was seriously ill and the worker directed the veterans' wife to the Boston Regional Office for procedures in pension application, accompanying legal information, etc; the wife was then able to carry through on this.

Six of the patients were referred to mental hygiene clinics in the community, so that they could receive psychotherapy there; this was in accord with the physicians' original requests to social service, as the patients were believed to have psychogenic symptoms without organic lesion. The symptoms which the men had were non-service-connected; this pointed toward outpatient psychiatric treatment from private sources, to avoid the waiting period for admittance of non-service-connected psychiatric patients at the hospital and to enable the veterans to continue their regular jobs. Four of the six were receiving pensions for injuries suffered in the armed forces; they were all World War II veterans and formed a predominantly youthful group, the eldest being forty years old. Five of these veterans were referred to mental hygiene clinics near their home; one was referred to his Veterans Administration Mental Hygiene Clinic for consideration for treatment there. Two of these patients realized that emotional factors were influencing their physical health, and they approached the

referral with a constructive and appreciative attitude. Three were acquiescent without much insight; they thought they really had physical ailments, but they respected the medical recommendation for psychotherapy. One blamed his physical symptoms on his current environment and he found it difficult to accept psychotherapy; this example was handled in a way similar to the referral of the man to a speech clinic, as mentioned above. Of the five cases other than this last, the referral mechanism was a letter to the clinics, as applied to four men, and a telephone call to the Veterans Administration Mental Hygiene Clinic, regarding one man.

Eight veterans were referred to domiciles for their maintenance, after they had received maximum hospital benefits. The non-specific request for social service had come from the doctors and the domiciliary plan was decided upon with the cooperation and consent of all who were involved. Seven of these veterans were past the age of fifty-three and all had chronic illness. The one person, aged thirty-one years, had had diverse forms of medical and psychiatric treatment but remained unable to assume responsibility for himself or his family. (He had had nine prior Cushing Veterans Administration Hospital admissions and four previous social service case openings and closures; he was the one mentioned in Chapter III, as being known to social service

both before and after the period under study.) He seemed to anticipate with pleasure the life in the suggested domicile, especially if he would be able to help with some of the work in the place. The social worker mentioned this latter point in her rather complete summary to the domicile. The other seven patients saw the reasons why they needed domiciliary care and they were able to adjust to this prospect, with the social worker's help. In all cases, their families could not assume their care; only two of the veterans were married and their wives were elderly and were invalids themselves. For four of the eight, the doctor handled the technical referral device by completing a regulation form for domiciliary care; for one, the patient's daughter made the arrangment; the social worker put through the plans for the other three. The referrals were all checked later and it was found that the actual moves to the domiciles had been completed successfully.

The referrals of six veterans centered around transportation problems. While transportation at the time of admission and discharge from the hospital may be provided at government expense, patients must pay their own way if they are leaving temporarily on pass or if they are receiving out-patient treatment. In these six cases, the Red Cross office in the city near the hospital, Framingham, was able to co-operate with the hospital social service staff in

meeting these needs. With four patients, the request was for a loan for the travel expense. With two, the Red Cross assisted with the actual transporting, as it seemed necessary in view of the patients' health. The referrals to Red Cross were all made by telephone, and with the four requesting cash, an affirmative answer was received in advance of sending the patients to that office. The patients' attitude toward these referrals naturally was accepting, as the referrals aided their plans.

Eleven referrals were mainly directed toward the patients' financial problems. Five of these were receiving monthly pension checks, while only one of this five listed dependents other than a wife. Four of the original requests came from physicians, four from veterans themselves, one from a routine tuberculosis reception contact, one from the admitting office, and one from the brother of a patient. With seven of the veterans, an explanation of the available facility, leaving the veteran to take the initiative, was considered sufficient. Of this seven, six were referred to their local Red Cross office. The results of the referrals were checked later in three cases and were found to have been satisfactory.

The social worker was more active in referring four cases, by telephone calls to the facility, perhaps because the situations seemed to require it more than the preceding

examples. Two men were referred to their respective town veterans service officers for financial aid because there had been definite recommendations that they should not work for specified periods of time. Two veterans were referred to the Red Cross; one concerned the request initiated by the brother of a veteran, as the veteran had a painful, terminal illness and the family could not pay for the necessary drugs. The other request by a woman veteran was for temporary financial aid; the hospital social worker thought the woman could use some casework service in the community, as well as the financial aid, and with the woman's approval, the referral was therefore made to the Red Cross. In all four of these active referrals, the caseworker was able to get a promise of aid from the facility at the time she telephoned.

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CHAPTER V

THE NON-REFERRED CASES

While it may seem almost superfluous to mention that medical social service naturally has many other purposes than referrals and that the goals for a particular case may not involve referral at all, still a few remarks on the other functions of hospital social work may be in order, to serve as background for the succeeding discussion on non-referred cases. In a large, complex organization such as a hospital, the patient may find it helpful to be able to talk with someone who has a particular understanding of his personal and social problems. In the social work interview, the paitent is made to feel that his anxieties, resistances, home and job situation, and the other parts of his living experience, are of interest to someone else and are considered in relation to his health and happiness. The acceptance of him and his attitudes by the social worker may serve as a release from needless tensions and misunderstandings and may help him to function better with his own adjustive capacities, to accept medical treatment, and to assume responsibility for his personal plans. The social worker often may speed the patient's recovery through relieving worries of the patient by making contacts for him which are not in the nature of referrals. Also, in fulfill-

ing her part in the medical-social team work the social worker's understanding of some of the environmental and emotional components affecting the patient may serve the medical staff very advantageously toward the improvement of the patient's total health.

Nine of the forty non-referred cases illustrate this last point; the respective physicians requested a social study, or in other words, exploration and evaluation of patient or family attitudes or situation. The doctors had inferred that these patients had problems of some sort. Social service worked supportively with these patients and co-operatively with the physicians, but no referral to extra-mural agencies was believed to be in order.

With another nine cases, the original requests came from the veterans themselves, Red Cross "grey ladies," and other hospital personnel, when the patient was in need of certain special services. These requests included clarification of insurance policies, income tax procedures, and other rather specific problems. The social workers were able to assist the patients with these details and found that their work with the patients did not indicate intensive service or community referrals.

In six cases, where the social workers classed their service as being primarily directed toward preparations for

the patient's discharge,* five of the requests came from physicians and one from the wife of a patient. Here, the social workers assisted the patients in plans, clarified medical recommendations as these would pertain to home and job activities, and judged that further referrals were unnecessary in these particular instances.

With two men, the physicians' requests to social service dealt especially with the occupations of the men, because of the medical recommendation that they should find less tiring work. Through the social workers' discussions with the younger man and with the hospital's vocational rehabilitation staff, arrangements were made for him to complete a course in pharmacology, which would be suitable to his inclinations and physical capacities. With the older man, social service was directed toward helping him accept his limitations and analyze his aims on a realistic basis, while emphasizing the opportunities and pleasures which were still available to him.

The usual casework procedures, including possible referrals, were suspended in three instances, where the original request for social service by the doctors was retracted because of a change in medical plans for the veterans.

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*For list of possible worker's classifications, see Appendix B.

Four of the non-referred cases were classed as "Immediate Service" in the social workers' statistics. This means that the contact was very short, either because the veteran was an out-patient or had left the hospital or because it had been immediately apparent to social service that the case indicated only a limited number of interviews. Of course, referrals were completed in other cases of this statistical classification, and these are included in Chapter IV. However, the fact that the contact was limited seems to bear some consideration in the present discussion, as the social worker was perhaps not able to explore other facets of the patient's adjustment than the initial request. This is associated with the element of efficient distribution of service by the worker with a heavy case-load; the worker must decide selectively as to which cases can manage with only a brief contact and which cases require a more intensive or long-term relationship. Two of the men initiated their own case opening with social service, the one requesting glasses and the other requesting dentures. As the first man was leaving the hospital, and as his eye condition was not service-connected, he could not be provided with glasses; through the efforts made by the social worker, his eyes were tested and he was given the prescription so that he could get the glasses following his discharge. The second man, an out-patient, wrote to the social service department,

saying that the dentures had previously been promised to him at the hospital (he was to have them fitted when his mouth was in condition for them.) The social worker handled this by speaking with the physician, who arranged for the patient's readmission for the fitting of the dentures and for a general check-up. With the other two examples of "Immediate Service," requests from outside agencies for information on the patients were made to social service. Following interviews with the patients to get their signed consent for release of information and with the doctors to get the medical reports, no further service was thought to be needed.

Another sub-division of these non-referrals may be distinguished in that the contact was broken off through forces beyond the control of the case worker. Six of the patients died during the project period. Two other patients left the hospital against medical advice; with one of these, the social worker had previously noticed that he had a problem personality, and he left the hospital when disciplinary action was threatened following a drinking spree. The other man seemed discouraged that his lung condition was not readily diagnosed, and he felt he could take care of himself at home just as well as in the hospital. He did not respond to the worker's attempts to help him accept the diagnostic and possible treatment period. It is to be noted that both

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of these men had been placed in the tuberculosis ward and had some fears that they would be infected by the other patients. However, the former had had surgery for a tuberculous involvement and the latter was suspected of having tuberculosis, and therefore there apparently was medical justification for their being placed in that ward.

With one man who was afflicted with psoriasis and rheumatoid arthritis, the request to social service originated from his wife, who felt that her husband needed help in accepting psychiatric treatment if this was recommended by the physician. She also offered to talk with the social worker herself if it was believed that she could be of aid in her husband's recovery. The patient seemed to be rather guarded in his interviews with the social worker, but he evidently did co-operate in accepting psychiatric treatment in the hospital, when this plan was later arranged by the physician. No outside referral was deemed advisable by the social worker.

With the remaining seven non-referrals, it appeared that referral to community agencies could have been beneficial, but the veterans were unaccepting of social service. The doctor of one arteriosclerotic patient asked that social service inquire into the man's home situation to see if this was a contributing factor in the hypertension and to get an idea as to the man's ability to follow medical recommendations

after discharge. The social worker interviewed the patient and the man's local veterans service officer interviewed the family. It was learned that the family was already known to many social agencies and apparently had profited little from these contacts; he was receiving financial assistance from veterans service. The social worker suggested a referral to the man, aimed at helping him with vocational problems, but he rejected this.

Three men past the age of fifty-five and with serious physical handicaps seemed to the social worker to need some community assistance, as applied to their health, vocational, housing, or financial planning. Nevertheless, they preferred to maintain their independence and take initiative themselves in changing their circumstances or in continuing their old pattern, unsatisfactory though it might seem to an objective observer. Having made sure that the men did understand the medical advice and the opportunities available to them in their home localities, the social worker preserved the patients' right of self-determination and did not intervene further.

The other three patients who were unaccepting of social service seemed to have personality problems that were probably not amenable to casework. One alcoholic with "psychoneurosis, mild," who was being discharged following treatment of his chronic bronchitis, had no plans in mind as to

after discharge. The social worker interviewed the patient and the man's local veterans service officer interviewed the family. It was learned that the family was already known to many social agencies and apparently had profited little from these contacts; he was receiving financial assistance from veterans service. The social worker suggested a referral to the man, aimed at helping him with vocational problems, but he rejected this.

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what he would do or how he would care for himself. He seemed to be against everyone, especially the government; he had been highly migratory in the past and was experienced in tapping community resources for aid. He rejected the case-worker's suggestions as to plans and preferred to leave the hospital with no particular decision in mind. Another patient was thought by his physician to need help in vocational plans; following his service in World War II, he had re-enlisted in the peace-time army and had been discharged only a month prior to his hospital admission. The social worker was unable to help this man to focus his aims. The veteran seemed to prefer leaving the hospital without a definite plan. The third man exhibited an unusual attitude, too, in that his ideas for his future seemed very vague and unrealistic to the social worker; he was a medical s tudent and intended to continue his studies but admitted that he did not have the necessary money and that he had a wife and child to support. The social worker also tried to approach him about his illness (abdominal pains) as this was considered by the doctor to be connected with emotional factors. However, he could not be drawn into a satisfactory discussion of this, either, or into accepting social service in other areas.

CHAPTER VI

ADDITIONAL COMMENTS ON THE STATISTICAL DATA

From the remaining data that was gathered, some other points may be drawn, to round out the picture of the medium in which these particular casework relationships operated.

It was found that the family of the veteran was directly contacted by the social worker in seventeen cases. This figure does not include visits which the hospital social worker asked other agencies to make. In seven of these seventeen cases, the records indicate that the patients' physical or mental health was such that the social worker considered it necessary to consult the family before any arrangements or plans could be made. It is to be hoped, of course, that the other families of veterans benefited in various ways by the patients' having casework services; however, under the Veterans Administration, the prime consideration must be the veterans. In considering the above figure for contacts with the family, it should be added that the social service department is not set up to do home visiting, and the hospital is not easily accessible to transportation routes.

Of the forty referrals, the results were checked later in twenty cases. This does not include the number of cases in which the social worker obtained, at the time of referral,

a promise of assistance for the veteran from the community agency.

In the original gathering of data, the writer thought it advisable to note the veteran's place of residence, as it was presumed that this would affect the availability of cooperating agencies. However, in examining the records, no instances were noted in which a referral was hampered by this factor. This held true even for the more specialized types of services such as psychotherapy. This may be associated with the degree of urbanization of Massachusetts and the surrounding territory, with the social workers' ability to utilize available resources fully, or with the initial request to social service (a physician may have known that the patient lived near a mental hygiene clinic before he asked social service to refer the patient to one.) The limited size of the study group may also have influenced this finding.

Another factor which was originally sought in the study and which was thought to be pertinent to the effectiveness of the social service referral, was whether the veteran had been told in advance by the physician or other source of the first request that a social worker would be seeing him and trying to help him with his problems. Because of the prevalence of summarized recording, this material was usually not available in the social service records; however, this

preparation had been done in some instances as regards steps which the patient might find it difficult to take, for example, referral to a mental hygiene clinic; the preparatory work seemed to have been very helpful where it was practiced.

The length of time which the social service case was open, the number of contacts made, and the space of time between the patient's hospital admission and his social case opening were also tabulated so that their association with the referral might be observed. The length of time which the cases were open ranged from three to 289 days, the mean being 61.7, the median being 49.5, and the mode being fourteen days. The number of days between hospital admission and social service opening ranged from the same day to 100 days, as shown in Table II.

TABLE II

DAYS BETWEEN HOSPITAL ADMISSION AND CASE OPENING*

Number of Days	Number of Cases
0 - 9	43
10 - 19	17
20 - 29	5
30 - 39	5
40 - 49	0
50 - 59	1
60 - 69	1
70 - 79	0
80 - 89	3
90 - 99	1
100 - 109	2

*The dates were unknown on two cases; the above figures exclude six out-patients.

TABLE II

DAYS BETWEEN HOSPITAL ADMISSION AND CASE OPENING*

Number of Days	Number of Cases
0 - 9	43
10 - 19	17
20 - 29	8
30 - 39	3
40 - 49	0
50 - 59	1
60 - 69	1
70 - 79	0
80 - 89	3
90 - 99	1
100 - 109	2

*The dates were unknown on two cases; the above figures exclude six out-patients.

"Contact," as described here and on the workers' statistical sheets, means interviews with patients and with hospital personnel and important telephone calls made in regard to the patient; it does not include letters or reports. The number of contacts made on these eighty-six cases ranged from one to forty-five, the mean being 9.67, the median being 7.36, and the mode being four contacts. On two cases, this figure was not known.

In regard to the length of time which the cases were kept open, in some instances this exhibits the continuing and varied services which were offered to the client; in others, it exhibits the use of a time lapse between the first contacts and those which may be of value to the patient later in his hospitalization.

The length of time which the case was kept open did not, therefore, have a direct correlation with the matter of referral or non-referral. Where the veteran's need indicated an immediate referral, this was accomplished, even if it was at the point of hospital discharge. However, as will be seen from Table II, more than half of the seventy-eight patients considered there became known to social service within the first nine days of their hospitalization. Though it was difficult to isolate exact material from the case records on this point, it may be presumed that, in general, social service is able to make a more valuable contribution,

for example in community referrals, if a patient becomes known to the department early in his hospitalization. This would probably affect the quality more than the quantity of referrals and would therefore not be clearly revealed in a study of the present type. Attempts to compare the number of contacts with the matter of referral or non-referral did not prove fruitful, either, apparently for the same reasons.

CHAPTER VII

SUMMARY AND CONCLUSIONS

Of the initial requests to social service in the veterans' behalf, fifty-four came from the attending physician, twelve from the veterans themselves, four from hospital Red Cross "grey ladies," three from routine rece ption contacts on the tuberculosis ward, one from the admitting office of the hospital, one from a nurse, one from a ward secretary, one from the hospital's Special Service department, four from friends or family members of the veterans, and five from other agencies. The complete list of requesting hospital staff members is given to show the alertness on the part of the personnel toward social problems; this interest of the staff members puts the social workers in touch with a wider range of problems than they would receive from the doctors or patients alone. The accepting of requests from outside agencies testifies to the social service department's cooperation with the community.

As mentioned in Chapter IV, the hospital social workers utilized, for the veterans, quite a number of community resources, including the Red Cross, a speech clinic, mental hygiene clinics, a public welfare department, a private family agency, a housing authority, a Visiting Nurse Association office, domiciles, different veterans service branches, and Regional Offices of the Veterans Administration. Where there was a telephoned or written referral and when the veteran had

given his permission, there was a sharing of helpful information with the other agency.

Fifteen of the forty referrals took place by telephone, eight by letter, and two others by telephone and letter both; four were technically handled by the doctor and one by the daughter of a patient, as mentioned in Chapter IV. In the other ten, the patient or a family member was to take the initiative.

A few tentative recommendations may be suggested; their use will necessarily depend on the surrounding reality factors which affect the working situation. It seems that where the community agency is being asked to carry on casework services with the veteran or his family, that agency should be provided by the hospital with a summary of pertinent facts; this might exclude some referrals made to Red Cross and veterans service solely for financial aid. A summary would also have to be used with caution where it would usually not be received by a social worker, e.g., in a domicile. In spite of the expense involved, the present writer believes that telephone calls to the community agency are often essential; these would not take the place of the more complete written summary but would first ascertain if the agency could and would provide the requested service to the veteran. Presumably these summaries and telephone calls would make it easier for the veteran to approach the agency himself, would allow the agency to profit by the hospitals' contacts with the patient, and would help to arouse

the agency's interest in the veteran. When sending a summary in a letter to the community agency, the hospital caseworker may then ask for a later report from the agency as to the veteran's use of the service thus offered. This may prove obviously helpful in that the patient may later be in the hospital again, at which time the hospital social worker will want this information.

The preceding chapters have shown something of the types of needs which the veterans may have, the varying attitudes of themselves and their families, and some of the aspects affecting the social workers' judgments as to the referrals. The material does not lead to any startling discoveries in comparing different categories. Just as the patients do have diversified problems and capacities, so must the social workers retain their individualized approach and flexibility and their knowledge of community resources and their working relationship with these.

Approved:
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Dean

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APPENDIX A

SCHEDULE

Code Number _____ Date Social Service Contact _____

Date Current Hospital Admission _____ Birth Date _____

Sex _____ Race _____ Marital Status _____

Religion _____ Occupation _____

Children Under 18 or Dependent Other Than Wife Yes _____
No _____

Time in Home Community Prior to Admission _____

Time in State _____ Residence Urban _____ Rural _____

Branch of Service _____ Dates of Service _____

Present Condition Serviced Connected Yes _____ No _____

Receiving Pension as Veteran Yes ___ No ___ Indicate _____

Admission Diagnosis _____

Diagnosis Following Study _____

Physical Illness Affect Ability to Work Through Plans with Social Service Yes ___ No ___

Social Worker Contacted Patient's Family Regarding Plans Yes ___ No ___

Referral to Social Service

A. Referred by _____ _____
_____ _____
_____ _____

B. Reason for Referral _____
_____
_____
_____

C. Patient Prepared for Referral to Social Service by Referring Party Yes ___ No ___ Unknown _____

Referral by Social Service

A. Patient was Referred to Facility Outside CVAH

1. Referred for _____
_____
_____
_____

2. Referred to

_____ _____
_____ _____
_____ _____

3. Patient's Attitude Toward Referral _____
_____
_____
_____

4. Referral Intended to Help Patient With
Physical Health _____
Mental Health _____
Social Factors _____
_____
_____

5. Social Worker's Steps in Referral

1. Letter(s) To Facility _____ 2. Telephone Calls to Facility _____ 3. Patient Told of Facility, Left to Take Initiative _____ 4. Other _____

6. Results of Referral Checked Later Yes ____ No _____

B. Patient Was Not Referred to Facility Outside CVAH

1. No Facility Available for Purpose _____
2. Patient Unaccepting of Help Offered _____
3. Referral Judged Unnecessary by Social Worker _____
4. Other _____

C. Number of Social Service Contacts, by Months _____

D. Social Worker's Classification of Major Services Rendered _____

APPENDIX B

Classification of Cases in Worker's Statistical Sheets According to Major Service Rendered

Under Continued Service:

Trial visit preparation
Trial visit supervision
Preparation for hospital discharge
Supervision after hospital discharge
Out-patient medical problems
Out-patient psychiatric problems
Occupation or training program problems
Social study
Other

Under Immediate Service:

Referred to other Veterans Administration facility
Referred to non-Veterans Administration medical agency
Referred to non-Veterans Administration other agency
No referral indicated